

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005434

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 13/3

FILED FEB 18 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Butter</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u> | | Length of stay in 1b <u>96 Days</u> | c. CITY OR TOWN <u>Lilbourn</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VA. Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>None</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>VIRGIL</u> Last <u>ADAMS</u> | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1963</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>2-23-17</u> |
| 9. AGE (last birthday) <u>45</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General Laborer</u> | |
| 11. BIRTHPLACE (City and state or country) <u>Caruthersville, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>John Adams</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sliza Scott</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>None</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW2</u> | |
| 16. SOCIAL SECURITY NO. <u>WW2</u> | | 17. INFORMANT Address <u>VA. Hospital Records, Poplar Bluff, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (b) <u>INTERCAPILLARY GLOMERULOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>Several Years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>8:35PM</u> Month, Day, Year <u>11-4-62</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>VA. Hospital</u> | 20f. CITY, TOWN, OR LOCATION <u>Poplar Bluff, Mo.</u> | | |
| 21. Resided the deceased from <u>11-4-62</u> to <u>2-8-63</u> and last saw her alive on <u>2-8-63</u> Death occurred at <u>8:35PM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert S. Cohen M.D. Chief, Med. Scv.</u> | | 22b. ADDRESS <u>VA. Hospital, Poplar Bluff, Mo.</u> | |
| 22c. DATE SIGNED <u>2-12-63</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 23b. DATE <u>2-10-63</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mounds Park</u> | |
| 23d. LOCATION (City, town, or county) <u>Lilbourn, Mo.</u> | | 24. FUNERAL DIRECTOR <u>Ponder Funeral Home-Lilbourn, Mo.</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>2-15-63</u> | | 26. REGISTRAR'S SIGNATURE <u>Thelma Graham</u> | |

(Licensed Embalmer's Statement on Reverse Side)

FEB 25 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold S. Pordew

Licensed Embalmer No. 5030

P. O. Address Liberty, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.